



RUPTURE OF ENDOMETRIOMA AT TERM DURING PREGNANCY: A RARE PRESENTATION

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INTRODUCTION :

Endometriosis is a disease that affects up to 10% of reproductive-aged women and is responsible for pain and infertility.¹ About 70% of women with mild to moderate endometriosis will get pregnant without treatment. But those who conceive, the clinical course of disease in them is variable and they suffer from various complications. Endometriosis does not always regress during pregnancy. Endometrial decidualisation in particular is responsible for many of the complications occurring during pregnancy.² It is not possible to estimate the incidence of endometrioma-associated complications as there are too few cases reported. The incidence of adnexal tumours in pregnancy is approximately 4%. 11.5% of these tumours are endometriomas. Approximately two-thirds of ovarian endometriomas reduce in size during pregnancy (40% disappear), 27% remain unchanged, and about 5% increase in size. However, 2.8% of pregnant women with endometrial cysts experience rupture,³ which is difficult to diagnose as gestation advances. When the clinical presentation is unclear further investigations must be undertaken dependant on gestation and including diagnostic/operative laparoscopy when indicated. Alternatively there should be a low threshold for caesarean section, particularly at advanced gestations.⁴

CASE REPORT:

We report a case of a ruptured ovarian endometrioma during pregnancy at term. A 33 year old unbooked primigravida presented to labour room at 38 weeks of gestation with complaints of lower abdominal pain and backache for 3 - 4 days and vaginal discharge for 6 hours. Abdomen was tense, fundal height of 40 cm and audible fetal heart sounds. No leakage of liquor seen at speculum examination. Internal and external cervical os were closed and full length. Obstetric ultrasound was normal but with increased liquor. Cardiotocograph was reactive. Labour induction was planned as initial clinical impression was of mild placental abruption. After 2 hours, mild uterine contractions started. However, no improvement in bishop score. Abdomen became more tense with increased tenderness and reduced variability on CTG. Emergency caesarean section was planned.

Intraoperatively anterior uterine wall was stained with dark brown chocolate like material. Baby delivered as cephalic with grade 2 meconium. Bilateral tubes were inflamed and dilated. Left ovary had ruptured cyst of 6 into 7 cm with 2cm rent in upper part of cyst wall. Greenish brown chocolate material was oozing from the ruptured site. Peritoneal cavity and omentum were also stained. Large gut adherent to posterior uterine wall and dense adhesions in pouch of douglas. Cyst wall removed and ovarian tissue conserved with ovarian reconstruction. Adhesiolysis and peritoneal lavage done. Histopathology of the cyst wall and omentum were consistent with endometriosis. Post operative recovery was uneventful.

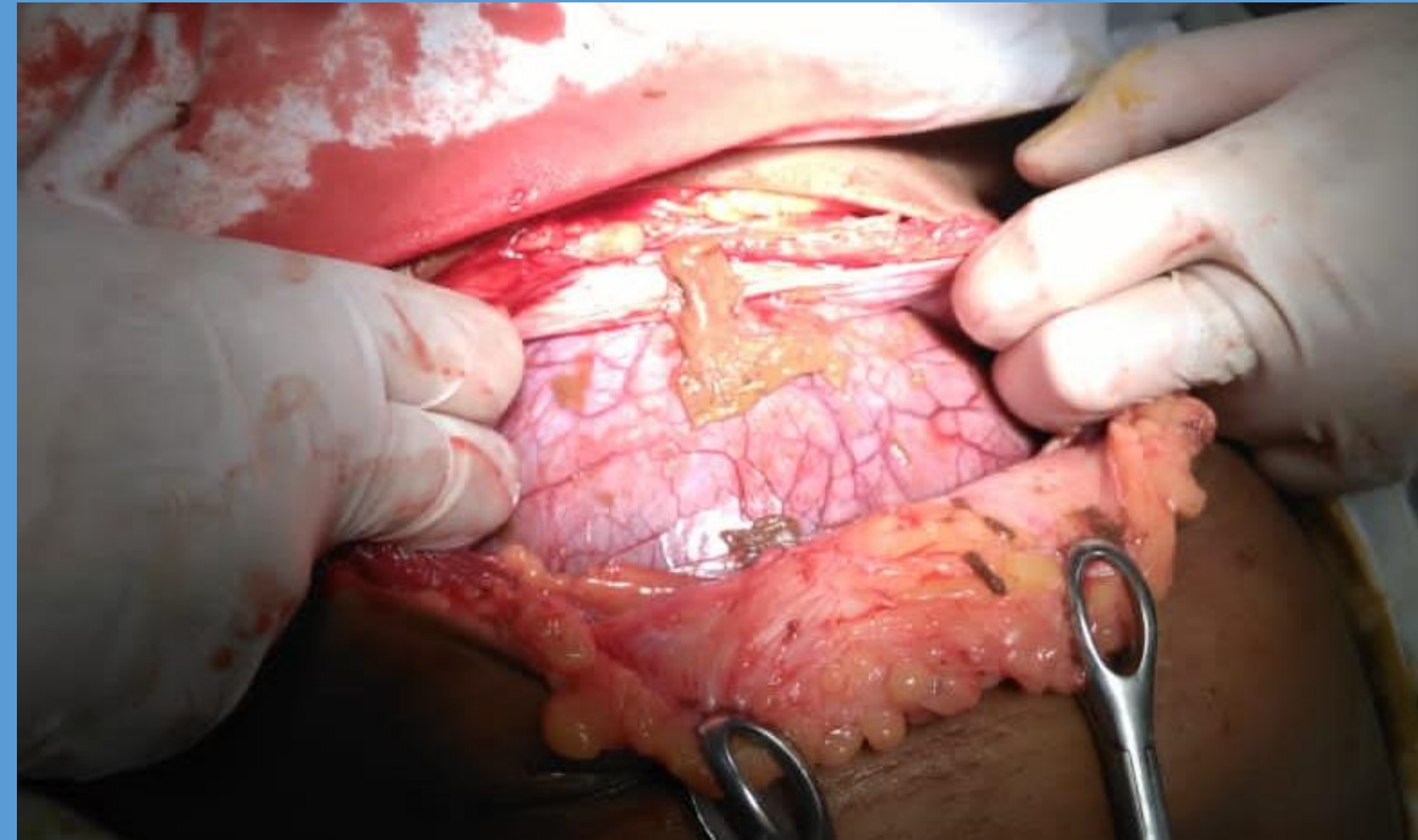


Figure 1:
Abdomen opened and peritoneal cavity stained with chocolate coloured material

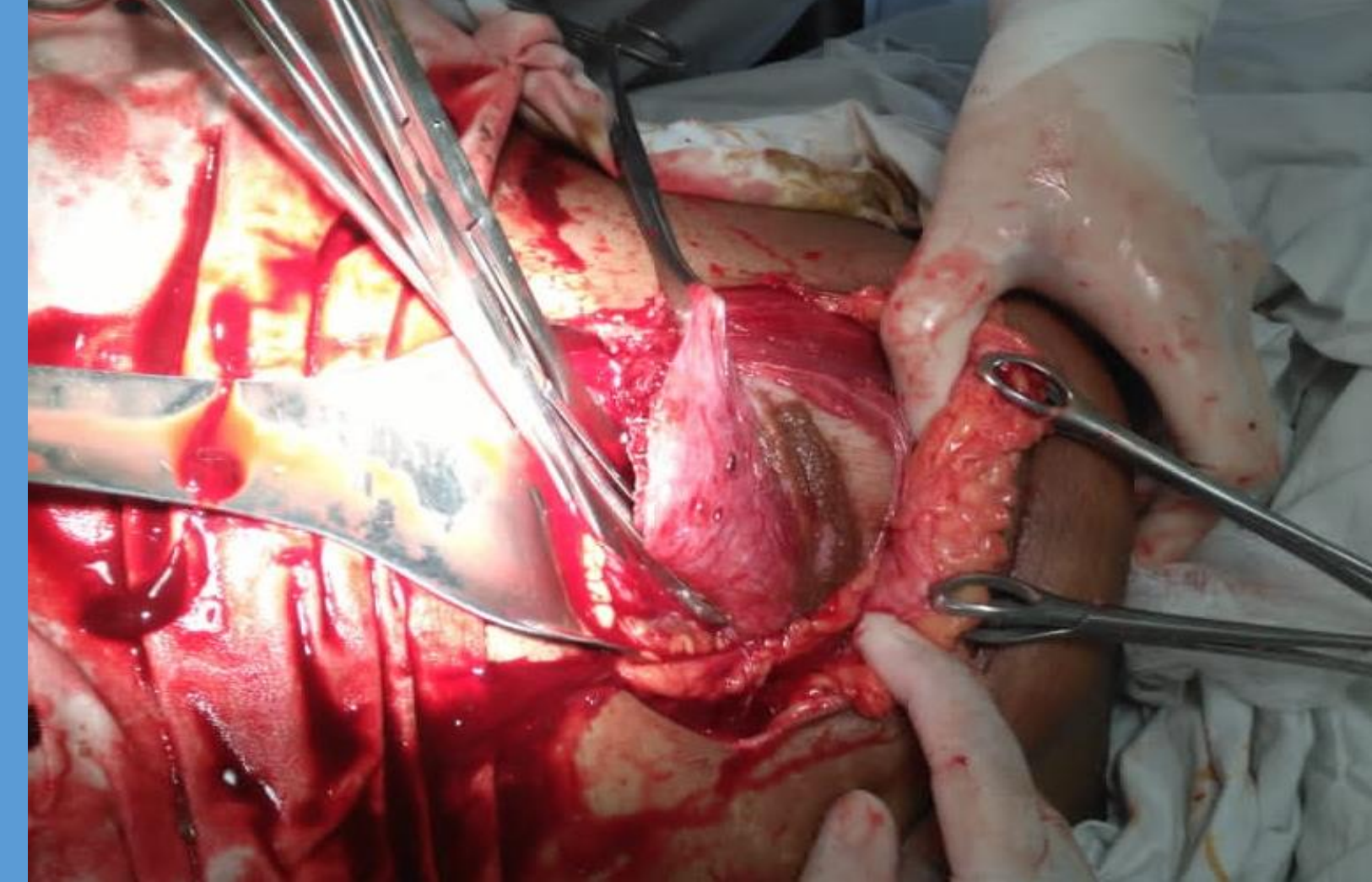


Figure 2:
Baby delivered as cephalic with grade 2 meconium

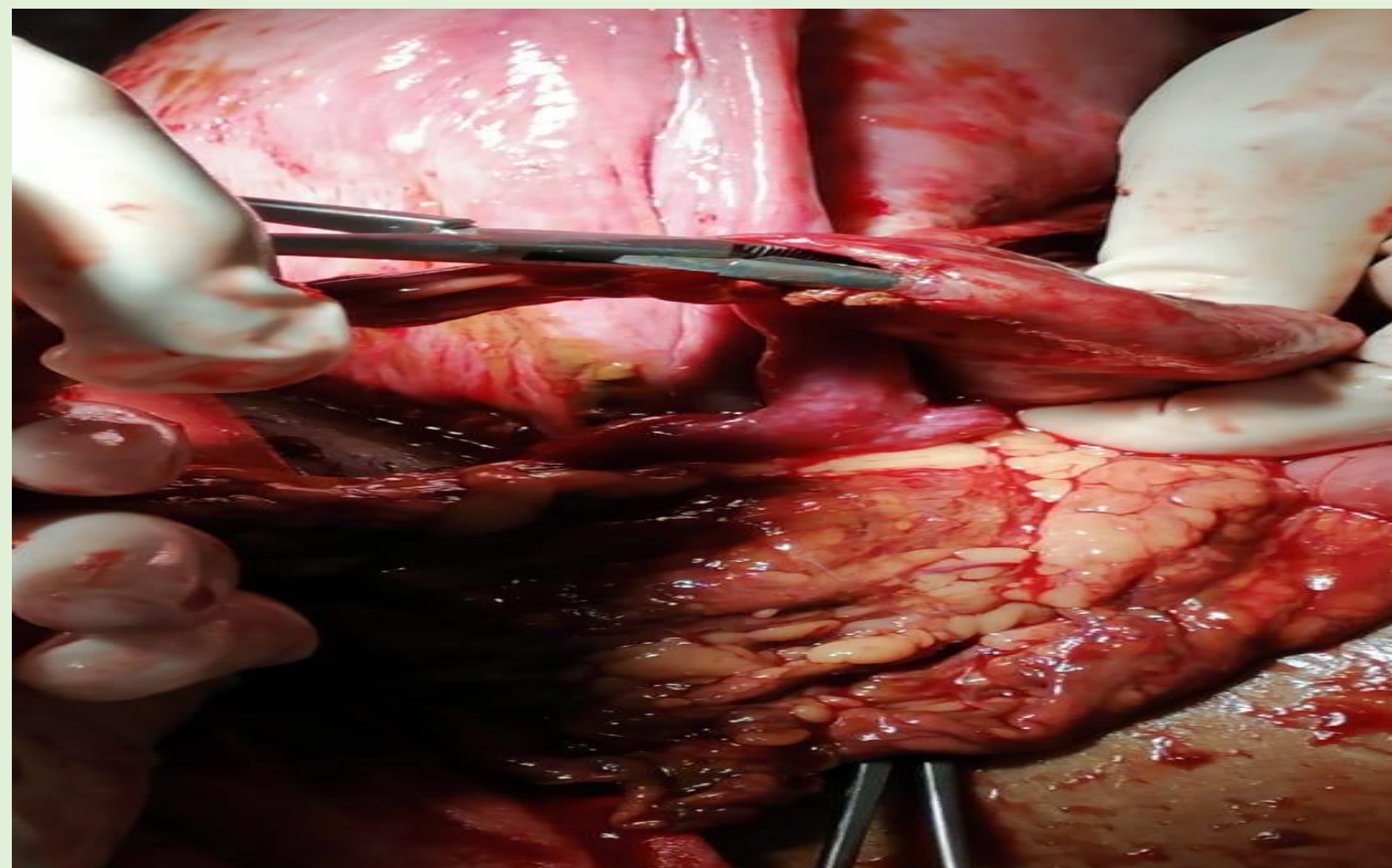


Figure 3:
Ruptured Endometriotic cyst



Figure 4:
Ovarian tissue conserved after removing cyst wall

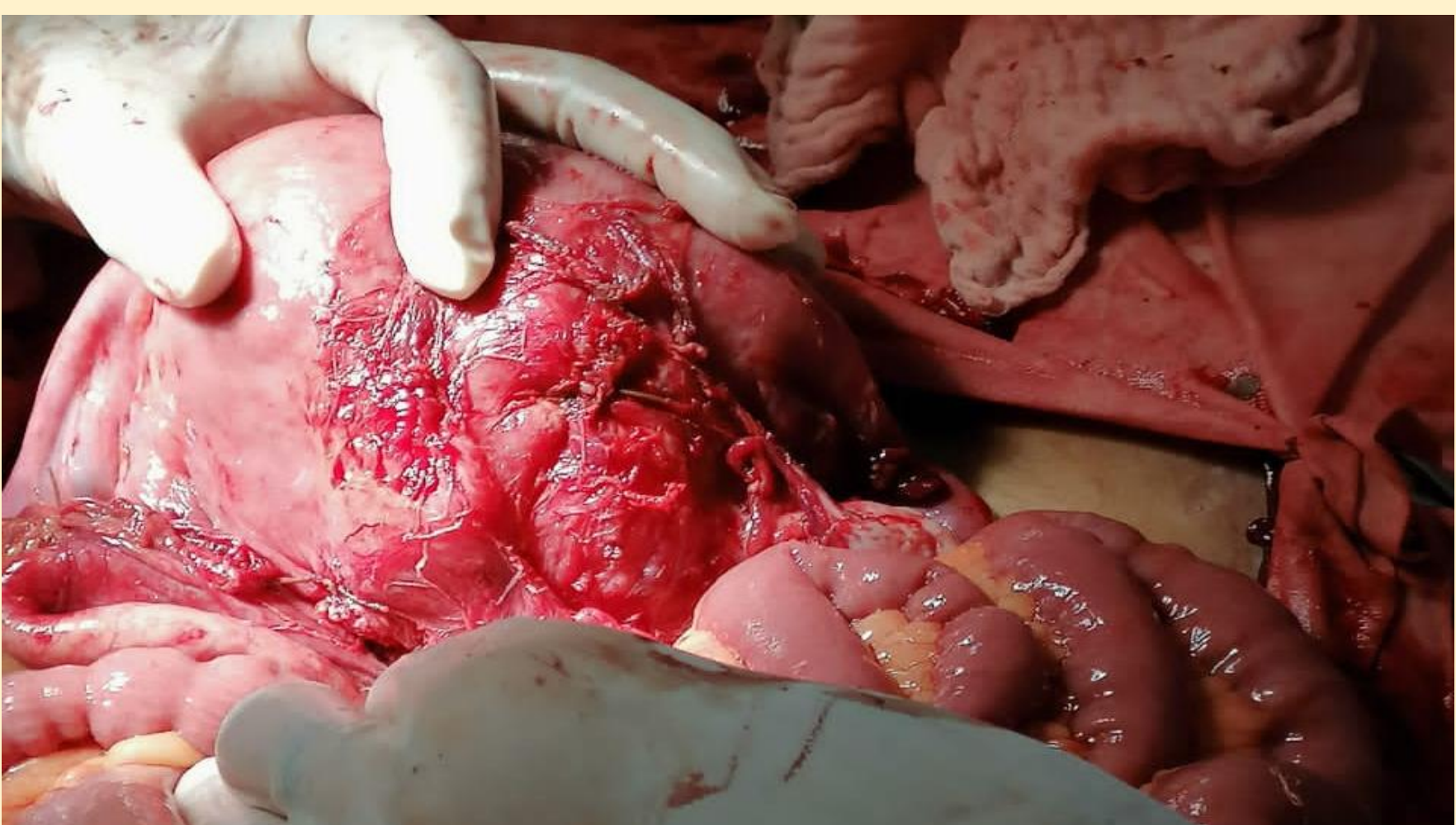


Figure 5:
Adhesiolysis done in pouch of douglas

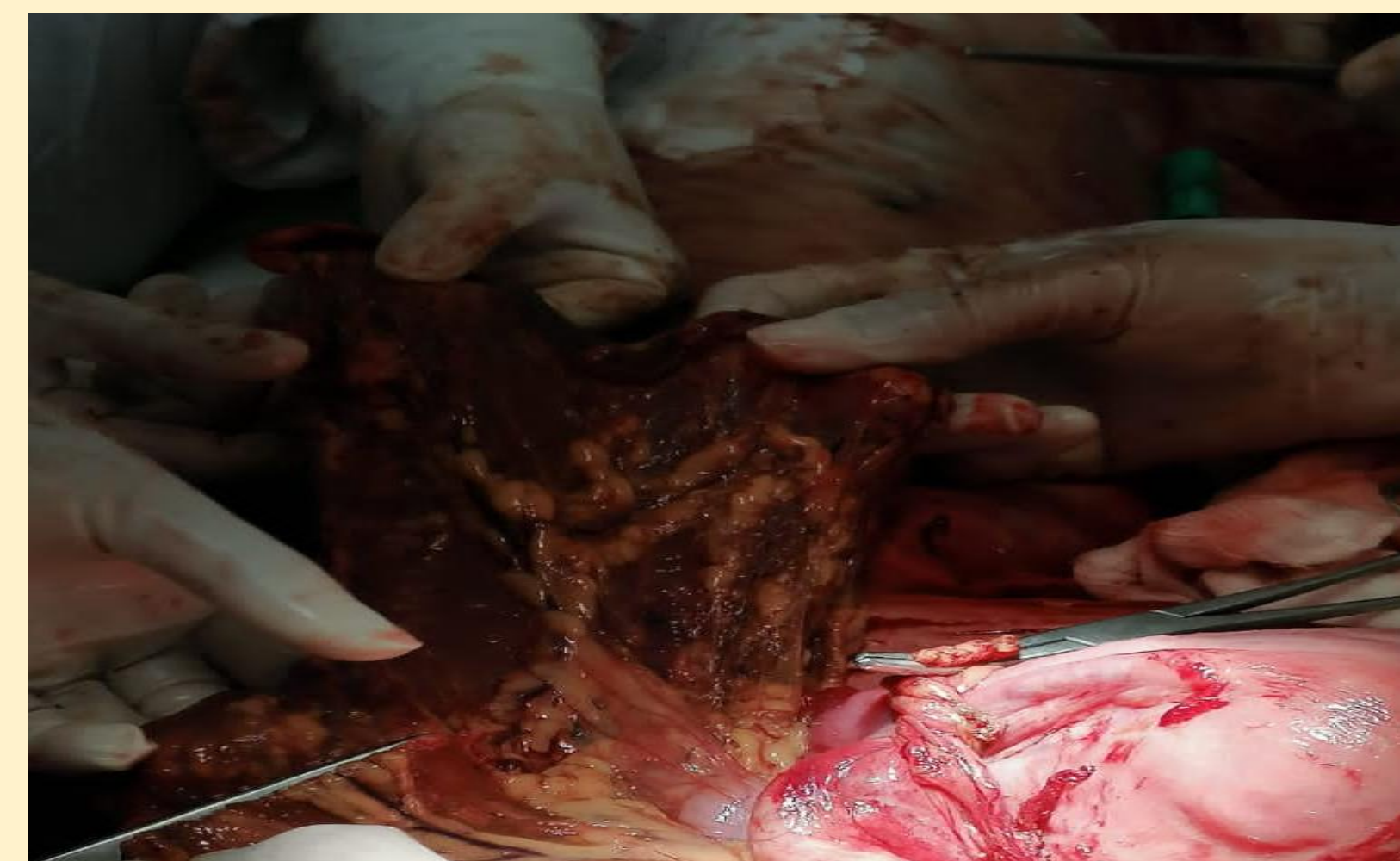


Figure 6:
Stained Omentum removed

Discussion:

Majority of endometriomas reduce in size during pregnancy. Persistence and rupture of endometrioma at term is a rare event³. This creates difficulty in diagnosing and differentiating from other obstetrical emergencies with similar presentation at term.

Conclusion :

Dense adhesions between the ovaries and the uterus cause increased tension as the uterus enlarges during pregnancy and contracts during labor, resulting in rupture of endometriomas. The areas of the endometriomas adherent peripherally are thinned out gradually as the uterus enlarges and finally become separated, resulting in escape of cyst contents. Patients with history of endometriomas should be monitored closely during pregnancy for increase in size and rupture of endometrioma should be kept in mind while dealing with obstetrical emergencies in patients presenting with abdominal pain.

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